# *A New Inpatient Hospital Payment Method for Montana Medicaid*

*The Montana Department of Public Health and Human Services (DPHHS) will move to a new method of paying for hospital inpatient services based on All Patient Refined Diagnosis Related Groups (APR-DRGs). Our goals are to implement a DRG grouper appropriate to Medicaid, reduce complexity, improve incentives, and reduce reliance on Medicare cost reports.*

*This document provides questions and answers about the new method. We invite additional questions and we welcome suggestions. The Department is working with a hospital technical advisory group convened by MHA on questions of payment policy, implementation and provider education.*

*Please note that details of the payment method shown in this document remain subject to change before the implementation date. For the latest information, hospitals and other interested parties are advised to check the Montana Medicaid website at the location shown in question 25*

**OVERVIEW QUESTIONS**

**1. When will the new method be implemented?**

Effective for claims with first date of service October 1, 2008.

**2. What change is being made?**

The Department will change its current payment method, based on CMS Diagnosis Related Groups (CMS-DRGs) to a new method based on All Patient Refined Diagnosis Related Groups (APR-DRGs). In addition, several features of the current method will be simplified.

**3. What providers and services will be affected?**

The new method will apply to almost all stays provided by acute care hospitals. This new method will apply to both general hospitals and specialty hospitals (e.g., psychiatric, rehab) as well as to distinct-part units.

Within these hospitals, inpatient payment methods will not change for Medicare crossover stays and swing-bed (nursing facility) stays.

Payment methods also will not change for critical access hospitals, Indian Health Service hospitals and the Montana State Hospital.

**4. How much money is affected?**

In the fiscal year ending June 30, 2007, Montana Medicaid paid hospitals $73.6 million for inpatient acute care, excluding Medicare crossovers and swing-bed stays. “Payments” refer to allowed amounts on the claims, which exclude supplementary disproportionate share payments and the net impact of cost settlement.

Of the $73.6 million, $9.8 million was paid to critical access hospitals. The sum affected by the new payment method will therefore be about $63.8 million a year (depending on changes in overall payments between FY 2007 and FY 2009).

**5. How does the current payment method work?**

As a general statement, payment is made on a per-stay basis using the same DRG grouping algorithm that CMS used for the Medicare program between October 1, 1983, and September 30, 2007. Since the Medicare and Medicaid patient populations differ greatly, the current Montana Medicaid payment method includes many customized features. Following are some of the key payment policies. Where payment is at cost, the claims are initially paid at a percentage of charges and then payments are retroactively adjusted after settlement of cost reports, a process that typically takes at least 18 months after the hospital fiscal year.

- ***Montana-specific relative weights.*** Relative weights are calculated based on the relative differences in charges levied by hospitals for treating Montana Medicaid patients.

- ***Split DRGs.*** 16 DRGs for mental health care are split, that is, Medicaid differentiates among patients more finely than Medicare does.

- ***Exempt DRGs.*** Some cases occurred too rarely in Montana for stable relative weights to be calculated. These DRGs are paid at a statewide percentage of charges.

- ***Cost outlier payments.*** If a hospital’s estimated loss on a case exceeds a certain threshold, then an additional cost outlier payment is added to the DRG base payment.

- ***Transfer payment adjustments.*** If a patient is transferred to another acute care hospital, payment may be reduced to a per diem payment.

- ***Prorated payment adjustment.*** If a patient does not have Medicaid eligibility for the entire hospital stay, then payment is reduced.

- ***Capital, medical education and disproportionate share payments.*** These items are paid separately through “add-on” payments that are specific to affected hospitals. Capital payment is at cost.

- ***Hospital residents.*** Patients with stays exceeding 180 days are paid at a statewide percentage of charges for all days exceeding the 180th day, subject to Department approval for the specific stay.

- ***Neonatal intensive care units.*** Neonatal intensive care services in designated Montana hospitals are paid at cost.

- ***Border hospitals.*** Hospitals within 100 miles of the Montana state line are paid using the same principles as Montana DRG hospitals except that the capital payment is a flat rate.

- ***Out-of-state preferred hospitals.*** Hospitals that agree to provide cost reports to Montana Medicaid and that receive prior authorization for inpatient stays are paid at 100% of cost.

- ***Out-of-state non-preferred hospitals.*** Other out-of-state hospitals are paid using the same DRG principles as border hospitals.

**6. Why change to the new payment method?**

- ***Use a grouper appropriate for Medicaid.*** Medicare will no longer maintain or update the CMS-DRG algorithm. Instead, Medicare has implemented Medicare Severity DRGs (MS-DRGs). The new MS-DRG algorithm is less suitable than CMS-DRGs for a Medicaid population.

- ***Simplify the payment method.*** The current method is too complex, with confusing incentives and too many exceptions.

- ***Reward efficiency.*** Of the $64 million in payments in SFY 2007 (excluding CAHs), roughly 55% was paid at percentages of charges or costs. Prospective payment incentives, which reward hospitals that reduce costs or restrain growth in charges, were used for only 45% of payments. Under the new method, over 90% of payments will be made using prospective payment principles.

- ***Reduce reliance on Medicare cost reports.*** Nationwide, Medicare audits only 15% of Medicare cost reports. Auditors concentrate their efforts on areas that are important to Medicare payment, which often differ from areas of key importance to Medicaid. As well, under payment at a percentage of cost both the Department and hospitals have to wait at least eighteen months for payment to be finalized. Under the new method, a hospital will receive final payment for a stay shortly after it submits a claim.

**PAYMENT CALCULATIONS**

**7. How will payment be calculated?**

For over 90% of stays, payment will be calculated very straightforwardly as the DRG relative weight times the DRG base price, which is known as the Gross DRG Amount. In addition, special payment calculations will be made in the following special situations

- ***Transfer adjustment.*** If the patient is transferred to another acute care setting (discharge statuses 02, 05, 43, 62, 63, 65, 66) then the stay will be checked for applicability of a transfer adjustment. The Gross DRG Amount will be divided by the nationwide average length of stay for that DRG to yield a per diem amount. The per diem amount will be multiplied by the actual length of stay plus one day (to reflect additional hospital costs associated with admission). If the calculated amount is less than the Gross DRG Amount, then the calculated amount will be paid. Otherwise, the Gross DRG Amount will be paid. Unlike Medicare, the Department will not have a post-acute transfer policy.

- ***Cost outlier payments.*** For exceptionally expensive cases, a cost outlier payment will be added. The cost of the stay will be estimated by multiplying charges on the claim by a statewide average cost-to-charge ratio (CCR). Effective for claims with first date of service October 1, 2008, the CCR will be set at 52% for all hospitals. The estimated cost will be compared with a DRG-specific cost outlier threshold. Any costs in excess of the threshold will be multiplied by a marginal cost percentage of 60% to yield the cost outlier payment.

- ***Prorated eligibility.*** In situations where the patient has Medicaid eligibility for fewer days than the length of stay, an adjustment will be made. The Gross DRG Amount, plus the cost outlier payment if applicable, will be divided by the nationwide average length of stay for that DRG to yield a per diem amount. The hospital will be paid the per diem amount times the number of days of Medicaid coverage, up to a maximum of the Gross DRG Amount plus the cost outlier payment.

- ***Interim claims*** If a stay exceeds 29 days and the hospital receives prior authorization, then the hospital may receive interim payments for interim claims. The interim payment will be a flat per diem rate ($400) times the number of covered days for the claim. When the patient is discharged, the hospital would submit a paper DPHHS Individual Adjustment Request for each interim claim, asking in section 8 that the previous claim be credited. The hospital would then submit a single admit-thru-discharge claim for the entire stay with type of bill 111; that claim would then be priced by DRG. If the hospital submits an admit-thru-discharge claim before adjusting the interim claims, the admit-thru-discharge claim would be denied as a duplicate. If the admit-thru-discharge claim is submitted with type of bill 114, the claim would be denied.

  The Individual Adjustment Request is available at www.mtmedicaid.org under "Forms." Montana Medicaid does not accept electronic adjustments (e.g., institutional type of bill 117 for replacements or 118 for voids).

  The availability of interim payments, which is unusual among DRG payers, is intended to promote access to care for patients whose care requires exceptionally long lengths of stay. Submission of interim claims is optional; the hospital can wait and submit a single claim after discharge if it chooses to.

- ***Hospital residents.*** In very rare circumstances, a patient may be in a hospital for more than 180 days. Payment for the first 180 days would be by DRG, with cost outlier payments as applicable. Payment for days exceeding 180 days would be 80% of estimated cost, which would be calculated as charges times the hospital-specific cost-to-charge ratio. In order to be eligible for the special hospital resident payment provision, the hospital must obtain prior approval from DPHHS and meet the following hospital residency status requirements in accordance with the Administrative Rule of Montana (ARM) 37.86.2921:

  (1) A recipient who is unable to be cared for in a setting other than the acute care hospital is eligible for hospital residency status.
  (2) To obtain hospital residency status, the recipient must meet the following requirements:
  (a) the recipient must utilize a ventilator for a continuous period of not less than eight hours in a 24-hour period or require at least 10 hours of direct nursing care in a 24-hour period; and
  (b) the recipient must have been an inpatient in an inpatient hospital for a minimum of six continuous months.
  (3) The provider will have the responsibility of determining whether services could be provided in a skilled nursing care facility or by the home and community based waiver program to a Medicaid recipient within the state of Montana.
  (4) The provider shall maintain written records of inquiries and responses about the present and future availability of openings in nursing homes and the home and community based waiver program.
  (5) A redetermination of nursing home or waiver availability must be made at least every six months.

**8. What is the DRG base price and how will it be updated?**

Effective October 1, 2008, the DRG base price will be set at:

- $4,129 for Montana hospitals, border hospitals, and most out-of-state hospitals
- $9,092 for rehabilitation and long-term care hospitals
- $6,890 for out-of-state hospitals that provide specialized services unavailable within Montana

As is the current practice, the base price will be reviewed each year, with any changes subject to the public notice requirements of the Administrative Rules of Montana.

**9. Will there continue to be separate payments for capital?**

No. Separate hospital-specific payment for capital will be discontinued. These payments will be folded into the DRG base price so that the net effect is budget neutral.

**10. What changes, if any, will be made to disproportionate-share hospital (DSH) payments and medical education payments?**

As part of this project, the Department does not intend to change payment policies and calculation formulas for supplementary DSH or routine DSH.

No add-on payments will be made for medical education.

**ALL PATIENT REFINED DRGS**

**11. Why were APR-DRGs chosen? Why not the same DRG system as Medicare uses?**

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal and pediatric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use. Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major or extreme) that are specific to the base APR-DRG.

CMS-DRGs—the algorithm currently used by Montana Medicaid and previously used by Medicare—were not chosen because CMS will no longer maintain or support their clinical logic. (From October 1, 2007, through Sept. 30, 2008, Medicaid is cross walking new diagnosis and procedure codes to previous codes that are recognized by the CMS-DRG algorithm. Such a crosswalk, however, is not a long-term solution.)

MS-DRGs—the algorithm now used by Medicare—were designed only for a Medicare population using only Medicare claims. In the Medicare program, just 4% of stays are for obstetrics, pediatrics, neonatal care and mental health. In the Montana Medicaid program, these categories represent 62% of stays.

**12. Who developed APR-DRGs? Who uses them?**

APR-DRGs were developed by 3M Health Information Systems and the National Association of Children's Hospitals and Related Institutions (NACHRI). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. APR-DRGs have been used to adjust for risk in analyzing hospital performance; examples are the "America's Best Hospitals" list by

*U.S. News & World Report*, state "report cards," and analysis done by organizations such as the Agency for Healthcare Research and Quality (AHRQ), the Medicare Payment Advisory Commission (MedPAC) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

APR-DRGs are also in use or planned for use in calculating payment by the state of Maryland, Pennsylvania Medicaid, Mississippi Medicaid, and Wellmark, the BlueCross BlueShield plan in Iowa.

**13. What was done and will be done to verify that APR-DRGs are appropriate for the Montana Medicaid population?**

ACS Government Healthcare Solutions conducted a feasibility study of alternative DRG algorithms. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Montana data very well, and better than CMS-DRGs. Results from the study were published in the January/February 2008 issue of *Health Affairs.* For a copy of the feasibility study or the *Health Affairs* article, contact Kevin Quinn at kevin.quinn@acs-inc.com.

The results for the Montana Medicaid population were similar to those found in an evaluation of national data that focused on neonatal care. That evaluation, published in the journal *Pediatrics*, is available at no charge at http://pediatrics.aappublications.org/cgi/reprint/103/1/SE1/302.

**14. In order to be paid, does my hospital need to buy APR-DRG software?**

No. The Medicaid claims processing system will assign the DRG and calculate payment without any need for the hospital to put the DRG on the claim.

If hospitals do wish to buy APR-DRG software, it is available from its owner, 3M Health Information Systems, or various other vendors. 3M has advised the Department that Montana hospitals may buy the basic APR-DRG software from 3M at the following prices, which reflect a base fee plus a multiplier for the annual volume of admissions.

- Hospitals with fewer than 1,000 admissions a year: $3,264 (maximum)
- Hospitals with 1,001 to 5,000 admissions a year: $4,052 (average)
- Hospitals with 5,001 to 10,000 admissions a year: $6,624 (average)
- Hospitals with more than 10,000 admissions a year: Depends on the number of admissions

Price increases would be limited to an inflation adjustment. 3M also makes the APR-DRG software available to other vendors (e.g., Premier, HBOC) so that APR-DRGs can be integrated into their systems. Hospitals can also choose to buy more sophisticated APR-DRG software from 3M or other vendors. In any case, any such arrangements are entirely between the hospital and the vendor. The Montana Medicaid program and ACS Government Healthcare Solutions have no financial interest in these decisions.

For hospitals interested in learning more about APR-DRGs, information is available at www.3m.com/us/healthcare/his/products/coding/refined_drg.html.

**15. What version of APR-DRGs will be implemented?**

APR-DRGs V.25 will be used for the initial October 1, 2008 implementation. APR-DRG V.26 will be implemented once it has been received from the vendor and tested within the Montana Medicaid claims processing system.

## CODING AND BILLING

### 16. How will the new payment method affect coding and billing?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields, so hospitals are advised to ensure that these fields are coded completely, accurately and defensibly. Hospitals may want to review their inpatient coding and make any necessary improvements as soon as possible.

### 17. How many diagnoses and procedures will be used in DRG assignment?

Currently the Montana Medicaid claims processing system uses the principal ICD-9-CM diagnosis, up to nine other ICD-9-CM diagnoses and up to six ICD-9-CM procedures in assigning a CMS-DRG. Under APR-DRGs, the system will use the principal ICD-9-CM diagnosis, up to 24 other ICD-9-CM diagnoses, the principal ICD-9-CM procedure, and up to 24 other ICD-9-CM procedures.

### 18. Will the Department require submission of the present on admission (POA) indicator?

Yes. Effective October 1, 2008, all hospitals must indicate whether or not the principal diagnosis and each secondary diagnosis was present on admission for inpatient stays.

Exempt hospitals as designated by Medicare may report a POA indicator "1" (exempt from POA reporting). Exempt hospitals currently include critical access hospitals, long-term care hospitals, Maryland waiver hospitals, cancer hospitals, children's inpatient facilities, inpatient rehabilitation facilities (IRFs) and psychiatric hospitals.

If a valid Present on Admission (POA) indicator is not reported, the claim will be denied.

The POA indicator must be reported in accordance with Medicare guidelines. Medicare reporting guidelines for the POA indicator can be located on the CMS web site at http://www.cms.hhs.gov/HospitalAcqCond/Downloads/poa_fact_sheet.pdf.

At this time, the Department will not adjust payment based on values of the POA indicator.

### 19. Will there be changes in prior authorization policy?

Effective October 1, 2008, the following inpatient stays will require prior authorization.

- All mental health stays, defined by APR-DRG. (For mental health stays, APR-DRG is almost always driven by the principal diagnosis code submitted by the hospital.)
- All transplant stays, defined by the APR-DRG, ICD-9-CM diagnosis codes, and/or ICD-9-CM procedure codes
- All interim claims if the hospital is seeking interim payment (applies only to stays exceeding 29 days)
- All stays exceeding 180 days if the hospital is seeking hospital resident payment

- All stays in out-of-state hospitals. This requirement does not apply to hospitals recognized by the Department as border hospitals, that is, within 100 miles of the Montana state line.

- Any specific ICD-9-CM diagnosis or procedure codes that currently require prior authorization.

**20. Will outpatient services related to the inpatient stay be bundled?**

Yes. A "related" service is defined as any outpatient service provided by the admitting hospital, or by another provider under arrangement with the admitting hospital, that is provided on the same calendar day as the admission or on the calendar day before the admission. This definition is intended to strike the appropriate balance between simplicity and precision in defining related outpatient services.

In the rare circumstance that a hospital provides emergency department services that are unambiguously unrelated to the admission, the hospital may appeal to the Department for separate payment of the ED services.

**OTHER QUESTIONS**

**21. Will hospitals still have to submit cost reports?**

Yes. The Department also uses cost reports in calculating hospital utilization fees and in reviewing hospital payments overall.

**22. Will payments be subject to adjustment after cost reports have been submitted?**

No. Payment based on DRG will be final.

**23. Will the new payment method have any impact on the provider tax calculations?**

No.

**24. Will there be an adjustment for documentation and coding?**

It is possible that the implementation of payment by APR-DRG will result in more complete coding by hospitals. It certainly will result in more complete capture of diagnosis and procedure codes by the Medicaid claims processing system. These factors may lead to an increase in average measured casemix and therefore in total payments to hospitals. At this time, the Department will not make a "documentation and coding adjustment" to offset any such increase. Instead, the Department will monitor changes in measured casemix and may make adjustments in the future.

**25. What has Medicaid done and what will Medicaid do to involve and inform hospitals during the development of the new payment method?**

- ***Montana Medicaid website.*** Updates of this FAQ and other documents are posted to the Montana Medicaid website at www.mtmedicaid.org. On the left-hand side, select "Resources by Provider Type," then "Hospital (Inpatient)," then "New APR-DRG Payment Method" (near the bottom of the page). Documents include the APR-DRG Table of Weights and Thresholds, pricing examples, and the presentations from provider trainings.

- ***Montana Medicaid Claim Jumper.*** Check our monthly provider relations newsletter for updates. It is mailed to all providers and is also available on the website.

- ***Technical consultation.*** The design and implementation of the new method has been and will be discussed in detail with a hospital advisory group at monthly meetings. These meetings are conducted by videoconference from the MHA office in Helena and are open to anyone.

- ***Financial simulation.*** Each hospital was provided with a stay-specific level financial simulation following the July 17, 2008 hospital advisory group meeting. Questions regarding the results of the financial simulation may be sent to David Bontemps at david.bontemps@acs-inc.com.

- ***Training sessions.*** Overviews of the new payment method was presented at the October 17, 2007 Healthcare Financial Management Association meeting in Billings and the April 24, 2008 Healthcare Financial Management Association meeting in Helena.

  Additional training sessions and presentations on the new payment method are scheduled as follows:
  - August 12, 2008 – Missoula, Community Medical Center
  - August 13, 2008 – Great Falls, Benefis West
  - August 18, 2008 – Bozeman, Bozeman Deaconess
  - August 19, 2008 – Billings, Billings Clinic

  A presentation is also planned at the October 2008 Healthcare Financial Management Association meeting.

**25. Who can I contact for more information?**

- ***Technical questions about APR-DRGs, outliers, etc.*** Kevin Quinn, Director, Payment Method Development, ACS Government Healthcare Solutions, kevin.quinn@acs-inc.com, 406-457-9550; David Bontemps, Senior Consultant, Payment Method Development, ACS Government Healthcare Solutions, david.bontemps@acs-inc.com, 404-551-4316.

- ***Questions about Department policy.*** Brett Williams, Hospital and Clinic Services Bureau Chief, Montana Department of Health and Human Services, bwilliams@mt.gov, 406-444-3634.

- ***Questions about participating in the technical advisory group.*** Bob Olsen, Vice President, MHA, bob@mtha.org, 406-442-1911.